Attachment 3 CA-2

Notice of Occupational Disease and Claim for Compensation

Reset Print

U. S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas. Employee complete areas highlighted in orange
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxe Supervisor complete areas highlighted in blue

Employee Data

1. Name of Employee (Last, First, Middle): Bear Smokey
2. Social Security Number: 555-55-5555
3. Date of birth (Mo. Day Yr.): 08/09/1964
4. Sex: M
5. Home telephone: 909-555-5555
6. Grade as of date of last exposure: Level 4 Step 1
7. Employee's home mailing address (Include city, state, and ZIP code): 1234 Conifer Lane; Employee's home address; Idllwild; CA; 92549
8. Dependents: [v] Wife, Husband; [ ] Children under 18 years; [ ] Other

Claim Information

9. Employee's occupation: Forestry Technician
   a. Occupation code:
10. Location (address) where you worked when disease or illness occurred (include City, state, and ZIP code): Priest Lake Ranger District 32203 Highway 57; Priest River; ID; 83856
11. Date you first became aware of disease or illness (Mo. Day Yr.): 02/10/20
12. Date you first realized the disease or illness was caused or aggravated by your employment (Mo. Day Yr.): 02/10/2009
13. Explain the relationship to your employment, and why you came to this realization

Repeated long hours of computer work right and left wrist hurting possible carpal tunnel

14. Nature of disease or illness

Both wrist hurting might be carpal tunnel

OWCP Use - NOI Code
b. Type code
c. Source code

15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in item #12, explain the reason for the delay.

16. If the statement requested in item I of the attached instructions is not submitted with this form, explain reason for delay.

17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay.

Employee Signature

18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act.

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government, agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the O[illegible]

Smokey Bear Date *2/10/2009*

Signature of employee or person acting on his/her behalf Date

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

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Official Supervisor's Report of Occupational Disease: Please complete information requested below

Supervisor's Report

19. Agency name and address of reporting office (include city, state, and ZIP Code)

USDA Forest Service
3900 Masthead NE, Annex WC
Albuquerque

OWCP Agency Code — FS WC Completes

OSHA Site Code — FS WC Completes

ZIP Code: NM 87109

20. Employee's duty station (Street address and ZIP Code)

32203 Highway 57 Priest River ID 83856

21. Regular work hours From: 700 a.m. / p.m. To: 330 a.m. / p.m.

22. Regular work schedule: Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

23. Name and address of physician first providing medical care (include city, state, ZIP code)

Complete blocks 23-25 if you know the physicians information

24. First date medical care received: Mo. Day Yr.

25. Do medical reports show employee is disabled for work? Yes No

26. Date employee first reported condition to supervisor: Mo. Day Yr.

27. Date and hour employee stopped work: Mo. Day Yr. Time a.m. / p.m.

28. Date and hour employee's pay stopped: Mo. Day Yr. Time a.m. / p.m.

29. Date employee was last exposed to conditions alleged to have caused disease or illness: Mo. Day Yr.

30. Date returned to work: Mo. Day Yr. Time a.m. / p.m.

31. If employee has returned to work and work assignment has changed, describe new duties

Supervisor be as detailed as possible

32. Employee's Retirement Coverage: CSRS FERS Other, (Specify)

33. Was injury caused by third party? Yes No
If "No," go to Item 34.

34. Name and address of third party (include city, state, and ZIP code)

Complete if applicable

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Supervisory Signature required

Name of Supervisor (Type or print)

Signature of Supervisor — Date

Supervisor's Title — Office phone

Form CA-2
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